Ridgeland Foot & Ankle Center

REGISTRATION FORM

(Please Print)

Today's date: ____________________ PCP: ____________________

PATIENT INFORMATION

Patient's last name: ____________________ First: ____________ Middle: ____________ ☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.

Marital status (circle one): Single / Mar / Div / Sep /Wid

Is this your legal name? If not, what is your legal name? ☐ Yes ☐ ____________________ (Former name): ____________ Birth date: ____/____/____ Age: ______ Sex: ☐ M ☐ F

Street address: ____________________ Social Security no.: ____________________ Home phone no.: (   ) ____________

P.O. box: ____________ City: ____________ State: ____________ ZIP Code: ____________

Occupation: ____________ Employer: ____________________ Employer phone no.: (   ) ____________

Chose clinic because/Referred to clinic by (please check one box):
☐ Dr. ☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Insurance Plan ☐ Hospital ☐ Other

Other family members seen here: ____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: ____________ Birth date: ____/____/____ Address (if different): ____________________ Home phone no.: (   ) ____________

Is this person a patient here? ☐ Yes ☐ No

Occupation: ____________ Employer: ____________ Employer address: ____________________ Employer phone no.: (   ) ____________

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance: ☐ Medicare ☐ Humana ☐ Blue Cross ☐ Cigna ☐ UHC ☐ Welfare (Please provide coupon) ☐ Other

Subscriber's name: ____________ Subscriber's S.S. no.: ____________ Birth date: ____/____/____ Group no.: ____________ Policy no.: ____________ Co-payment: ____________

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable): ____________ Subscriber's name: ____________ Group no.: ____________ Policy no.: ____________

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): ____________ Relationship to patient: ____________ Home phone no.: (   ) ____________ Work phone no.: (   ) ____________

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Ridgeland Foot & Ankle Center or insurance company to release any information required to process my claims.

____________________ ____________________

Patient/Guardian signature *Date*